



NORTHWEST ANIMAL CLINIC & HOSPITAL
1000 ALAMEDA BLVD NW ALBUQUERQUE, NM 87114
505 898-1491 FAX 505 898 0407 EMERGENCY PAGER 269-2256

Patient Name Sex Date of Birth Color
Breed Species Microchip/Tattoo ID #
Owner(s) Driver's License #
Responsible Party DOB
Telephone Home () Cell () Email
Address: City ST ZIP
Mailing Address: City ST ZIP
Employer daytime number ()

Important medical information

The Reason for this visit:

Has this patient experienced any of the following:

- yes no -- Gaining weight or Losing weight ? (circle one)
yes no -- Spayed/Neutered Year
yes no -- Limping
yes no -- Scratching
yes no -- Seizures
yes no -- Depressed /listless
yes no -- Ear problems
yes no -- Eye problems
yes no -- Fainting or weakness
yes no -- Lumps or bumps
yes no -- Coughing, sneezing, wheezing (circle all that apply)
yes no -- Increased water consumption
yes no -- Urination changes/difficulties
yes no -- Bad breath
yes no -- Increased or Decreased appetite (circle one)
yes no -- Other?
yes no -- Vomiting
Stools are : Normal or Abnormal (circle one)

Diet consists of
Previous history of serious illness/operations:
List vaccines and dates administered
Current medications:
Pet obtained from:
Thank you for coming to NWAC&H. You have selected us for this reason

I am the owner, or the agent of the owner, of the above described animal and have the authority to execute this consent. I hereby consent and authorize the performance of the listed procedure or operation. I understand that during the performance of the procedure or operation, unforeseen conditions may be revealed that necessitates extension of the listed procedure, or operation, of different procedure(s) or operation(s) than those set forth. Therefore, I hereby consent to and authorize the performance of such procedure(s) or operation(s) as are necessary and desirable in the exercise of the veterinarian's professional judgment. I also authorize the use of appropriate anesthetics and other medications and I understand that hospital support personnel will be employed as deemed necessary by the veterinarians to provide the necessary care for this animal. I have been advised as to the nature of the procedure or operation and the risks involved including death. I realize that results cannot be guaranteed.

A Deposit of 50% is required \$ Cash Credit Card Check Care Credit
Payment is due at time of service.

I have read and understand this authorization and consent to the listed procedure.

Signature: Date: Phone #:
Ok to text? Yes [] No []
Patient Name Sex Date of Birth / /